U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 July 2007

Case No. 2005-BLA-5890

In the Matter of:
B.S.,[1]
Claimant,

v.

GOLDEN OAK MINING CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
James D. Holliday, Esq.,
On behalf of Claimant

David H. Neeley, Esq.,
On Behalf of Employer/Carrier

BEFORE: Thomas F. Phalen, Jr.
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On May 18, 2005, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 43).[3] A formal hearing on this matter was conducted on July 26, 2006 in Hazard, Kentucky, by the undersigned Administrative Law Judge. (Tr. 1). All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[4]

The issues in this case are:

1. Whether this claim was timely filed;

2. Whether the miner worked in or around coal mines for 37 years;[5]

2. Whether Claimant has pneumoconiosis as defined by the Act;

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank*, 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia*, that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[4] At the hearing the Employer withdrew as uncontested the following issue: dependency. (Tr. 11).

[5] Employer stipulated to at least 20 years of coal mine employment, while the Director found 29. (Tr. 10-11).

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled;

5. Whether Claimant's disability is due to pneumoconiosis;

6. Whether the Claimant has established a material change in conditions per §725.309(c),(d); and

7. Other issues which will not be decided by the undersigned but are preserved for appeal. (Item 18(b), DX 48).

(DX 48).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

B.S. ("Claimant") was born on December 28, 1940 and was sixty-five years old at the time of the hearing. (DX 3; Tr. 13). He completed the tenth grade. (DX 3; Tr. 13). In August of 1960, Claimant married D.L.H., and they remain married and living together. (DX 3; Tr. 14). Claimant has no other dependents. (Tr. 14).

On his application for benefits and at the hearing, Claimant alleged he engaged in coal mine employment for thirty-seven years. (DX 3; Tr. 14). The Director found twenty-nine years, and Employer has stipulated to an "excess" of twenty years of coal mine employment. (DX 37; Tr. 14).[6] Claimant began working in the coal mines when he was around fifteen years old. (Tr. 14). He was paid in cash for a number of his jobs. (Tr. 14-15). His coal mine employment ended in March of 1993 due to an injury he suffered in his left hand. (Tr. 16). Claimant never had subsequent employment after leaving the mines. His current family doctor is Dr. Bilecki, and he has been seeing her since 1993. (Tr. 18). His currently pulmonary specialist is Dr. Alam. (Tr. 20).[7]

Procedural History

Claimant filed his initial claim for benefits under the Act on October 22, 1993 which was denied. (DX 1). Claimant filed again in October of 2000 and was again denied. (DX 1).[8]

[6] *See* Tr. at 10 for Employer's stipulation.
[7] He was referred to Dr. Alam by Dr. Bilecki. Tr. at 20.
[8] Claimant also filed in February 2002, but withdrew his claim. (DX 1).

On April 22, 2004, Claimant filed the instant claim for benefits under the Act. (DX 3). The Director issued a proposed decision and order – award of benefits on February 7, 2005. (DX 37). Employer timely requested a formal hearing before the Office of Administrative Law Judges. (DX 38). The matter was transferred to this office on May 18, 2005. (DX 43).

Length of Coal Mine Employment

Claimant stated on his application that he engaged in coal mine employment for thirty-seven years. (DX 3). The Director determined that Claimant established twenty-nine years of coal mine employment. (DX 37). Employer stipulated to an excess of twenty years, but still listed length of employment as an issue.

Claimant was a coal miner within the meaning of § 402 (d) of the Act and § 725.202 of the regulations.

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to ascertain the beginning and ending dates of coal mine employment by using any credible evidence. There are several permissible sources of credible evidence. First, an administrative law judge may rely solely upon a coal mine employment history form completed by the miner. *See Harkey v. Alabama-By-Products Corp.*, 7 B.L.R. 1-26 (1984). A miner's uncontradicted and credible testimony may also be the exclusive basis for a finding on the length of miner's coal mine employment. *See Bizarri v. Consolidation Coal Co.*, 7 B.L.R. 1-343 (1984); *Coval v. Pike Coal Co.*, 7 B.L.R. 1-272 (1984). If the miner's testimony is unreliable, it is permissible for an administrative law judge to credit Social Security records over the miner's testimony. *See Tackett v. Director, OWCP*, 6 B.L.R. 1-839 (1984).

I do not find a major discrepancy between the coal mine employment listed on Claimant's CM-911a employment summary, the Social Security Earnings record, and Claimant's supporting statements and reports. (DX 1-7). However, Claimant testimony, which I find to be credible, establishes that he was paid in cash for about two years of coal mine employment – which was standard back in the 1960s. Thus, I find that the Social Security Earnings as verified by Claimant's summary form in conjunction with his testimony, to be the most reliable source to determine Claimant's length of coal mine employment. The regulatory provisions at 20 C.F.R. §725.101(a)(32) (2001) make reference to a table developed by the *Bureau of Labor Statistics*. However, this table does not exist. Rather, the Department uses a table, which is identified as Exhibit 610 of the *Office of Workers' Compensation Programs Coal Mine (BLBA) Procedure Manual*. The Social Security Earnings report reflects the following coal mine employment earnings history:

Year	Earnings	Industry Average for 125 days of CME	Years of Coal Mine Employment
1959	$ 618.11	$ 2,661.25	0.23
1960	$ 476.91	$ 2,687.50	0.18
1961	$ 329.37	$ 2,645.00	0.12

Year	Earnings	Industry Average for 125 days of CME	Years of Coal Mine Employment
1962	$ 1,441.70	$ 2,717.50	0.53
1963	$ 1,345.18	$ 2,835.00	0.47
1964	$ 773.65	$ 3,031.25	0.26
1965	$ 2,341.35	$ 3,222.50	0.73
1966	$ 3,735.81	$ 3,438.75	1.00
1967	$ 4,247.84	$ 3,662.50	1.00
1968	$ 4,862.98	$ 3,801.25	1.00
1969	$ 3,640.58	$ 4,261.25	0.85
1970	$ 7,800.00	$ 4,777.50	1.00
1971	$ 7,800.00	$ 5,008.75	1.00
1972	$ 9,318.10	$ 5,576.25	1.00
1973	$ 14,469.86	$ 5,898.75	1.00
1974	$ 13,200.00	$ 6,080.00	1.00
1975	$ 14,100.00	$ 7,405.00	1.00
1976	$ 15,300.00	$ 8,008.75	1.00
1977	$ 16,500.00	$ 8,987.50	1.00
1978	$ 17,700.00	$10,038.75	1.00
1979	$ 22,900.00	$10,878.75	1.00
1980	$ 23,935.21	$10,927.50	1.00
1981	$ 29,700.00	$12,100.00	1.00
1982	$ 30,715.12	$12,698.75	1.00
1983	$ 21,583.30	$13,720.00	1.00
1984	$ 28,092.48	$14,800.00	1.00
1985	$ 26,291.58	$15,250.00	1.00
1986	$ 29,138.75	$15,390.00	1.00
1987	$ 28,643.58	$15,750.00	1.00
1988	$ 28,220.57	$15,940.00	1.00
1989	$ 31,009.33	$16,250.00	1.00
1990	$ 28,316.77	$16,710.00	1.00
1991	$ 34,345.81	$17,080.00	1.00
1992	$ 39,777.32	$17,200.00	1.00
1993	$ 8,783.54	$17,260.00	0.51
Total years of coal mine employment in records:			**29.88**

Claimant testified that he began working in the coal mines back in 1955, and I found his testimony to be credible. (Tr. 15). He stated that he was paid in cash during that time. However, according to the Social Security records, it appears that Claimant was not yet working a "full year" in the 1950's. Therefore, I shall credit Claimant only two additional years of coal mine employment. Thus, based on Claimant's Social Security records and his testimony, I find that Claimant's length of coal mine employment is thirty-two years.[9]

[9] I note that Claimant's earnings for 2004 are not included in the Social Security records. He listed that he stopped working on March 15, 2004. (DX 4). However, without any evidence to verify that Claimant was in fact employed, I cannot credit him with his 2004 employment.

Claimant's last coal mine employment was in the Commonwealth of Kentucky (DX 1, 3, 6, 7). Therefore, the law of the Sixth Circuit is controlling.[10]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Golden Oak Mining Company, L.P. ("Employer") as the putative responsible operator due to the fact that it was the last company to employ Claimant for a full year. (DX 37). Employer, however, contests this issue. After reviewing the evidence and reading Employer's brief, I find the evidence supports that Employer last employed Claimant in this nation's coal mines for more than a year.[11] (DX 7; Tr. 14). Therefore, I find Golden Oak Mining Co. is correctly identified as the responsible operator.

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

However, in a subsequent opinion, the Sixth Circuit adopted a position which states that when a doctor determines a miner is totally disabled due to pneumoconiosis, and a subsequent

[10] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

[11] I note Employer did not address this issue in its brief.

judicial finding holds that the claimant is not totally disabled due to pneumoconiosis, the medical determination must be a misdiagnosis and cannot "equate to a 'medical determination' under the statute." *Peabody Coal Co. v. Director, OWCP*, 48 Fed. Appx. 140 at 146 (6th Cir. Oct. 2, 2002)(unpub.). In summary, "if a miner's claim is ultimately rejected on the basis that he does not have the disease, this finding necessarily renders any prior medical opinion to the contrary invalid, and the miner is handed a clean slate for the statute of limitation purposes." *Id.*

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.[12]

Here, Employer states (and Claimant so testified) that Dr. Alam told Claimant approximately four years ago (late 2000 or February of 2001) that he was totally disabled by pneumoconiosis. (Tr. 30; *See* Employer's Brief at 3). While there is no requirement that such a determination be in writing, *Kirk* requires that the medical opinion communicated to the miner be both well reasoned and well documented. Here, there is no record upon which I can evaluate Dr. Alam's reasoning in giving a diagnosis of total disability due to pneumoconiosis.[13] Thus, Employer has not rebutted the presumption under § 725.308(c) that this claim was timely filed. Hence, I find this claim was timely filed.

NEWLY SUBMITTED MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under Section 725.414(a)(2)(i) and (3)(i) or Section 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of Sections 725.414(a)(2) or (a)(3), any record of a miner's

[12] I find that when *Kirk*, *Peabody Coal*, and *Ferguson* are in pari materia, the following principal of law emerges: In order that a communicated diagnosis of total disability of pneumoconiosis be sufficient to bar a black lung claim on the basis of timeliness, the communicating physician's report must be both well reasoned and well documented. Nevertheless, while I have applied this standard in the instant case, I note that this claim would not be barred under § 725.308(a) under any of the above cases.

[13] There are some treatment records from Dr. Alam located at DX 25. I have determined that these treatment notes are unreasoned for the purposes of diagnosing pneumoconiosis. *Infra* at 24.

hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under Section 725.414. § 725.406(b).

Claimant selected Dr. Glen Baker to provide his Department of Labor sponsored complete pulmonary evaluation. (DX 10). Dr. Baker conducted the examination on May 25, 2004. (DX 11). I admit Dr. Baker's report under Section 725.406(b).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 3). Claimant designated Dr. Alexander's November 2004 reading of the May 24, 2004 x-ray as initial evidence. (DX 34). As rebuttal evidence, Claimant submitted Dr. Alexander's May 26, 2006 reading of the May 24, 2004 x-ray. (CX 1).[14] Claimant designated the PFTs conducted by Dr. Fino on September 9, 2004 and by Dr. Alam on May 24, 2004 as initial evidence, and Dr. Burki's reports of May 25, 2004 and July 29, 2004 as rebuttal of the Department PFTs. (DX 27, 25, 11). Claimant also designated Dr. Alam's ABG conducted on May 24, 2004 as initial evidence. (DX 25). In terms of initial medical reports, Claimant designated the reports of Dr. Alam dated June 12, 2004 and Dr. Fino dated September 23, 2004. (DX 16, 27). He also designated Dr. Baker's deposition dated June 19, 2006 as rehabilitative evidence. (CX 2). Finally, Claimant designated treatment records from Mountain Comprehensive Health Care. (DX 25). Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit Claimant's evidence as designated in the Summary Form.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 2). As initial evidence, Employer designated the x-ray readings of Dr. Fino dated September 9, 2004 and Dr. Halbert dated May 24, 2004. (DX 27, 26). As rebuttal to the Department x-ray, Employer submitted Dr. Halbert's reading of the May 25, 2004 x-ray. (DX 33). Employer submitted the PFT and ABG studies of Dr. Fino dated September 9, 2004 as initial evidence. (DX 27). Under the medical reports, Employer submitted Dr. Broudy's report dated November 22, 2004 and Dr. Dahhan's report dated May 23, 2006. (DX 36; EX 1). As Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3), it is admitted for consideration in this claim.

X-RAYS

Exhibit	Date of X-Ray	Date of Reading	Physician/Qualification	Film Quality	Interpretation
DX 26	5/24/04	09/20/04	Dr. Halbert / B-Reader, BCR	2	0/0
DX 34	5/24/04	11/19/04	Dr. Alexander / B-Reader, BCR	2	1/1

[14] A rebuttal of the Department sponsored x-ray is permissible under *Sprague v. Freeman United Coal Mining Co.*, BRB No. 05-1020 BLA (Aug. 31, 2006)(unpublished). In this case, the Board held that "rebuttal" evidence need only refute "the case" presented by the opposing party rather than refute a particular piece of evidence. Specifically, the Board held that the Administrative Law Judge should have allowed Claimant's positive x-ray rereading to "rebut" a positive x-ray interpretation underlying the § 725.406 pulmonary evaluation.

DX 11	5/25/04	05/25/04	Dr. Baker / B-Reader	1	1/0
DX 33	5/25/04	11/23/04	Dr. Halbert	2	0/0
DX 27	9/09/04	09/20/04	Dr. Fino / B-Reader	1	0/0

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height[15]**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**	**Comments**
DX 25 5/24/04	Good/ Good/Yes	63/74	1.80	2.88		62	Yes	Limited Study; Flow/Volume loop is not complete. Difficult test attempted five times – patient became very short of breath and experienced near syncope.
DX 11 5/25/04	Fair/ Good/Yes		1.82	4.57		40	Yes	Invalid
DX 25 5/26/04	Good/ Good/Yes	63/74	1.32 1.64*	2.12 2.41*	25	62 68*	Yes Yes	Moderate restriction with positive bronchodilator response.
DX 11[16] 7/29/04	Poor/ Good/Yes	63/72	1.64	4.73		35	Yes	Invalid

[15] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). As the three reports show varying heights from 72-74 inches, I will use the midpoint and find the miner's height to be 73 inches.

[16] Both PFTs were invalidated by Dr. Burki due to suboptimal effort. DX 11. Under the regulations, where the deficiencies in a PFT are the result of a lack of effort on the part of the miner, "the miner will be afforded one additional opportunity to produce a satisfactory result." §725.406(c). Here, the Director provided Claimant with a second opportunity to produce satisfactory results. Even though the second effort was not satisfactory and the results are useless in determining total disability, I find that the Director has met his burden in providing a complete pulmonary evaluation under § 725.406(c).

DX 27 9/09/04	Poor/ Good/Yes	63/72	1.72 2.08*	4.13 4.79*		42 43*	Yes Yes	Moderately severe reversible obstructive ventilatory defect.

* Indicates Post-Bronchodilator Values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**	**Comments**
DX 25	5/24/04	36.1	75.8	No	
DX 11	5/25/04	36.0	76.0	No	
DX 27	9/09/04	35.0	79.0	No	

Narrative Reports

Dr. Glen Baker, who is board certified in internal and pulmonary medicine, as well as a B-reader, examined Claimant on May 25, 2004 and submitted a report. (DX 11). A clarification report was submitted on August 31, 2004 and Dr. Baker was also deposed on June 19, 2006. (DX 24; CX 2). Dr. Baker stated that Claimant suffered from both clinical and legal pneumoconiosis, which contributed in part to his totally disabling respiratory impairment. In so concluding, Dr. Baker considered the following: an age of sixty-three; an EKG report showing a poor R wave progression; an employment history of thirty-six years, last working as a foreman; family history of high blood pressure, heart disease, and stroke; a personal history of frequent colds, attacks of wheezing, chronic bronchitis, arthritis, heart disease, and high blood pressure with serious conditions of an ulcer in the 1970's, a kidney stone in 1968, back injuries in 1963 and 1993, and a hand injury in 1993; a smoking history of nine years with less than a half pack a day; present complaints of 14 years of daily sputum, wheezing, dyspnea, cough, with several years of hemoptysis, two years of chest pain, 10-12 years of orthopnea, and several years of ankle edema; physical examination revealing decreased breath sounds bilaterally; objective tests, including x-ray (1/0), PFT (moderate obstructive ventilatory defect), and an ABG (mild resting arterial hypoxemia). After considering all the above, Dr. Baker diagnosed CWP, COPD with a moderate obstructive ventilatory defect, hypoxemia, and chronic bronchitis – all of which is attributed in part to coal dust exposure. Dr. Baker described the impairment as "moderate," relying on the FEV1 between 40-59% of predicted values. According to Dr. Baker, the low FEV1 values in conjunction with the mild resting arterial hypoxemia and chronic bronchitis showed Claimant does not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. Thus, according to Dr. Baker, Claimant is totally disabled by pneumoconiosis (both clinical and legal).[17]

In his deposition, Dr. Baker is able to also consider additional evidence. First, he examined Dr. Fino's PFTs, which showed a moderately severe obstruction with reduction in the FEV1 with some improvement after bronchiodilators. Dr. Baker stated these studies further

[17] He states so specifically in his letter of clarification. DX 24.

reflected his opinion from previous tests and his physical examination that Claimant could not perform the work of a coal miner and rendered him totally disabled. He disagreed with Dr. Broudy's finding of asthma – as Dr. Baker opined that coal workers' pneumoconiosis can cause an obstructive defect to this degree of impairment. Dr. Baker noted Dr. Broudy felt there was "some inherent predisposition to asthma," but stated he could not see from the evidence how such a diagnosis could be made. The cigarette smoking history – which was uniform between the two physicians – would not cause such an impairment according to Dr. Baker. Given Claimant's history of exposure and lack of other contributing factors, Dr. Baker concluded within a degree of reasonable medical certainty that the etiology of Claimant's pulmonary impairment is due to a long history of coal dust exposure.

Dr. M. Alam provided a written report dated June 12, 2004.[18] (DX 16). He diagnosed legal pneumoconiosis and a totally disabling pulmonary impairment due to coal dust exposure. He did not elaborate upon his findings, or articulate his basis for the findings. However, he did state that coal dust exposure "substantially aggravated" Claimant's condition, which resulted in moderate impairment. Dr. Alam also opined that Claimant no longer possessed the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment.

Dr. Gregory Fino, who is board certified in internal and pulmonary medicine, and holds B-reader credentials, examined Claimant on September 9, 2004 and submitted a report. (DX 27). In addition to his examination, Dr. Fino also considered the following reports: DOL sponsored examination dated May 25, 2004; CT Scan dated May 27, 2004; PFT dated May 24, 2004; an undated PFT showing a severe obstructive ventilatory defect with a reversibility over 12%; and treatment notes from Mountain Comprehensive Health Corporation dated August 23, 1993-August 3, 2004. In concluding that Claimant suffered from moderately severe chronic obstructive bronchitis, a reversible bronchospasm, and emphysema, Dr. Fino also considered the following: an age of sixty-three years; current medications; half a pack day smoking history of nine years (1984-1993); thirty-seven years of coal mine employment ending in 1993 with his last job as that of foreman for twelve years (which required heavy labor); symptoms (shortness of breath for eighteen years and getting worse, dyspnea when walking or performing any lifting and carrying; chest pain; daily cough and mucus production with wheeze); personal history of tumor removal from his right leg in 1960's, slipped disc in 1992, crushed left hand requiring surgery in 1993, black lung diagnosis in 1993, severe chronic arthritis all his life, cyst removed from right kidney in 2002, heart problems, chronic bladder problems, and chronic bone problems; no history of pneumonia, tuberculosis, emphysema, asthma, bronchitis, bronchiectasis, frequent colds, or fractured ribs; a family history of heart disease and lung disease;[19] a physical examination revealing decreased breath sounds, normal heart rhythm and a blood pressure of 130/70; and the objective evidence (in addition to the outside reports outlined above) consisting of a negative x-ray (0/0), a PFT (moderately severe obstructive ventilatory defect showing significant reversibility), and an ABG (normal). In considering Claimant's employment and lack of a significant smoking history, Dr. Fino opined that coal dust exposure contributed to Claimant's overall respiratory impairment and disability. Dr. Fino made no finding as to

[18] It appears the "12" may have been written over in place of either a "14" or "16." It is impossible to tell. (DX 16).

[19] Claimant's father had black lung.

whether Claimant possessed the pulmonary capacity to return to his former coal mine employment or employment of similar arduous labor in a dust free environment.

Dr. Bruce Broudy, who is board certified in both internal and pulmonary medicine and holds B-reader certification, was deposed on November 22, 2004.[20] (DX 36). In providing his opinion, Dr. Broudy reviewed the following evidence: a comprehensive examination by Dr. Fino, x-ray reading by Dr. Halbert, examination report by Dr. Alam, office notes from his treating physician regarding hypertension and degenerative joint disease, as well as sinusitis, asthma, wheezing, and stress, and finally the examination report by Dr. Baker. Based upon this review, Dr. Broudy opined that Claimant does not suffer from coal workers' pneumoconiosis or legal pneumoconiosis. Furthermore, Dr. Broudy believes the evidence does not show that Claimant is totally disabled from a pulmonary standpoint. He does acknowledge that Claimant has chronic obstructive airway disease with some reversibility, but opines that it is the result of chronic obstructive asthma and cigarette smoking in the past.[21] He specifically states that he can draw this conclusion because:

> Chronic obstructive asthma which, of course, is a very common condition occurring in about seven percent of the population in Kentucky. For one thing, he [Claimant] had some reversibility to his airway obstruction which is uncommon or virtually absent in patients with obstruction due to pneumoconiosis. Furthermore, he had a prior history of cigarette smoking which may also cause obstruction.

(DX 36). Even though pneumoconiosis is a progressive disease, Dr. Broudy says that it is not within the realm of reasonable medical probability that pneumoconiosis would manifest itself so long after Claimant left the mines. He considered the PFTs reported by Dr. Alam to be invalid as they did not have tracings to confirm their validity. Also, he considered the PFTs conducted on May 24, 2004 to be invalid due to less than optimal effort.

Dr. Dahhan, who is board certified in both internal and pulmonary medicine, conducted a medical evidence review and submitted a report dated May 23, 2006. (EX 1). In drawing his conclusions, Dr. Dahhan considered the following: Dr. Broudy's deposition, x-ray dated May 24, 2004 read by Dr. Alexander; x-ray dated May 25, 2004 read by Dr. Halbert; Dr. Fino's report dated September 9, 2004; x-ray dated May 24, 2004 read by Dr. Halbert; office notes from Dr. Alam dated June 14, 2004; echocardiogram dated June 10, 2004; CT scan dated May 28, 2004; x-ray dated May 24, 2004 read as "clear lung fields"; PFT from Dr. Alam's office; office note by a physician whose signature he could not read dated June 21, 2005; and Dr. Baker's report dated May 25, 2004. After examining all this evidence, Dr. Dahhan concluded within a degree of medical certainty that: 1. Claimant has bronchial asthma; 2. that he does not retain the respiratory capacity to continue his previous coal mining work or a job of comparable physical demand; 3. that Claimant does not have clinical pneumoconiosis (based upon a majority of the x-rays being negative, and the negative CT scan); and 4. that there are no findings which can justify a diagnosis of legal pneumoconiosis (his bronchial asthma is a condition of the general

[20] It was stated in this deposition that a written report of Dr. Broudy would be attached as exhibit 1. No such exhibit is attached to DX 36.

[21] He states that neither of these conditions could be aggravated by coal dust exposure.

public at large and is not caused by, related to, contributed to, or aggravated by the inhalation of coal dust). His diagnosis of bronchial asthma is based upon the history of frequent wheeze and shortness of breath, and treatment with bronchodilator agents shows significant response to these medications.

Treatment Records

Contained at DX 25 are treatment records from the Mountain Comprehensive Health Care. Specifically, there are two PFT results, both of which are interpreted by Dr. Mahmood Alam. However, the tests results submitted to this court do not contain the three tracings as required by § 718.103(b). As such, I find these PFT results are not in compliance with the Act and are entitled to no weight.

Included in the treatment notes are x-ray reports from several physicians.[22] There is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. §718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. §718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

Also contained in the treatment records are numerous reports which are based of treatment for high blood pressure, back pain, ear pain, arthritis treatment, heartburn, and other conditions besides a pulmonary condition. Section 725.414(a)(4) allows for the admission of "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease." §725.414(a)(4). Therefore, if the hospital admission or treatment was based on a pulmonary impairment, the record is admissible notwithstanding the limitations in Sections 725.414(a)(2) and (a)(3). The records which are not based upon the treatment of a pulmonary condition shall not be considered.

The treatment records also contain a CT scan report dated May 28, 2004 by a Dr. Pampati. The report stated that there was evidence of lymph nodes in the carinal area. There was also evidence of poorly calcified granuloma in the lungs noted bilaterally more on the left than the right. Even though the CT scan was conducted to detect pneumoconiosis, the disease is not mentioned.

An ABG dated May 24 is included, the results of which are articulated above.

[22] Most of the x-ray reports are not of the chest, but of the back and hip.

Office Notes:

-August 3, 2004 from Dr. Bielecki stating that Claimant's lungs are clear, but diminished.

-June 14, 2004 from Dr. Alam. He states the workup shows Claimant has moderate airflow obstruction with restriction. The CT scan results are noted. It was communicated to the Claimant that they needed to find out the etiology for the dyspnea. Most likely, Dr. Alam articulated it was chronic bronchitis with coal workers' pneumoconiosis because of his long history of mining. The lung examination revealed good bilateral air movement with no wheezes or crackles. Dr. Alam describes Claimant as a patient "with chronic cough, coal workers' pneumoconiosis, chronic bronchitis, and dyspnea on exertion."

-June 10, 2004 from Dr. Garimella. The fact Claimant has a prolonged exposure to mining and has clinical pneumoconiosis with a class III dyspnea associated with orthopnea, PND, and mild leg edema and right heart failure is noted. Dr. Garimella notes Claimant's chest discomfort is mostly in the left precarinal and left retrosternal area, sharp in character and transient in nature – not related all the time with exertion. However, Claimant's prominent symptoms include significant shortness of breath and he was sent there to exclude any significant concomitant coronary disease. Dr. Garimella notes that Claimant has a chronic mild hemoptysis with upper respiratory tract infection and bronchitis. Upon examination, the lungs showed decreased breath sounds on bases.

-May 5, 2004 from Dr. Bielecki stating that Claimant has shortness of breath with coughing and wheezing. It is noted that Claimant is scheduled to see a black lung specialist in Corbin. Dr. Bielecki notes that Claimant is not currently a smoker and his lungs sound clear.

-September 21, 1998 from Dr. Bielecki for treating a sinus headache. Lungs were clear but showed diminished breath sounds upon examination.

-October 20, 1997 from Dr. Bielecki when Claimant came in for treatment of a head cold. The lungs were clear upon examination.

-May 12, 1994 from Dr. Asif stating Claimant came in because of nighttime breathing problems and dyspnea on exertion. A history of coal workers' pneumoconiosis is mentioned. Physical examination shows moderately decreased air entry on both sides but no wheezing

Smoking History

At the hearing, Claimant stated he smoked for about eight or ten years of his life, but primarily chewed tobacco. (Tr. 21). He stated he has not smoked since 1993. (Tr. 21). This is consistent with the history he provided to all the physicians who provided examinations in conjunction with his claim for black lung, who all listed Claimant as having smoked for ten half-pack years.[23] This would equate to five pack years. As such, I find Claimant has smoked for five pack years, having quit in 1993.

[23] However, there are treatment records indicating that as of September 12, 1995, Claimant may have been smoking a half pack a day, and as of February 5, 2004, he may have been smoking three quarter packs a day. This

DISCUSSION AND APPLICABLE LAW

Claimant's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section;

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202);

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203);

   (iii) Is totally disabled (see § 718.204(c));

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Compamy*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the

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information was provided to his doctors in association with his blood pressure problems. However, I find that these treatment records are not admissible under § 725.414(a)(4). Furthermore, neither party addressed or briefed on this issue. Therefore, I credit neither the implication that Claimant was continuing to smoke up to ¾ pack a day, nor any argument that he had a ten pack year history of smoking. Section 725.414(a)(4) allows for the admission of "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease." Here, the records containing the smoking history are not from the treatment of a pulmonary or respiratory condition. The Board specifically stated in *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc) that an administrative law judge cannot view the medical records as a whole, but must "analyze each set of records and made a specific finding as to its (sic) admissibility under § 725.414(a)(4)."

> provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

§ 725.309(d) (April 1, 2002).

Claimant's prior claim was denied after it was determined that he failed to establish any of the elements of entitlement. (DX 2). Consequently, the Claimant must establish, by a preponderance of the newly submitted evidence, at least one applicable condition of entitlement previously adjudicated against him.

Total Disability

Claimant may establish a material change in conditions by demonstrating that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines*

Corp., 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons,* 9 B.L.R. 1-4 (1986).

There is no evidence of complicated pneumoconiosis in the record. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. Also, in *Crappe v. U.S. Steel Corp.*, 6 B.L.R. 1-476 (1983), the Board held that a non-conforming PFT may be entitled to probative value where the study was not accompanied by statements of miner cooperation and comprehension and the ventilatory capacity was above the table values. This is because any deficiency in cooperation and comprehension could only result in higher results.

The first PFT contained in the record dated May 24, 2004 is invalid because the flow/volume loop is not complete. The second PFT dated May 25, 2004 was found invalid by Dr. Burki due to suboptimal effort. The third PFT dated May 26, 2004 is invalid because it is not accompanied by three tracings. The forth PFT dated July 29, 2004 was invalidated by Dr. Burki due to poor effort. The final PFT, dated September 9, 2004 is the only valid PFT in the record. It produced qualifying results before and after bronchodilators were administered. As the only valid PFT produced qualifying results, I find that Claimant has established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of ABGs meet the requirements listed in the tables found at Appendix C to Part 718. None of the ABGs produced qualifying results. I therefore find that Claimant has not established the existence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment was that of a foreman and required heavy manual labor such as lifting up to 100lbs at one time, and lifting thousands of pounds of dust bags per day. (DX 1). This continued until Claimant left the coal mining industry in 1993.

Dr. Baker opined that Claimant was totally disabled from a pulmonary impairment. Even though he acknowledged that his PFTs were invalidated, he relied upon Dr. Fino's PFT to support his position (the valid one of record – which was very similar to one he conducted).

Furthermore, Dr. Baker stated the ABG showed a mild hypoxemia, and the physical examination he conducted backed his conclusions. As such, given Dr. Baker's superior credentials, the fact he relied upon objective evidence and his own physical examination, I find his opinion to be both well reasoned and well documented on the issue of total disability. Thus, given his superior credentials, I accord his opinion substantial probative weight.

Dr. Alam's written opinion only states the conclusion that Claimant is totally disabled from a pulmonary impairment. (DX 16). He provides no reasoning, nor does he state any objective evidence upon which he relies in drawing his conclusion. As such, I find his opinion here to be neither well reasoned nor well documented. Thus, it is accorded no weight for the purposes of determining total disability.

Dr. Fino provided no direct opinion on the issue of total disability. He did state that he considered, after examining the objective evidence, Claimant to suffer from a moderately severe chronic obstructive bronchitis. However, he proffered no opinion as to whether Claimant possessed the pulmonary capacity to return to his former coal mine employment or similar employment. Therefore, I accord his opinion on the issue of total disability no weight.

After conducting a medical evidence review, Dr. Broudy opined that Claimant was not totally disabled from a pulmonary standpoint. He only stated in response to a question that he did not believe, after reviewing the evidence, that Claimant was not totally disabled from a pulmonary standpoint. It is not clear what specific objective evidence he relied upon, but he did state that Dr. Alam's PFTs lacked tracings, so he could not rely upon them. Dr. Broudy also felt the PFT dated May 24, 2004 showed less than optimal effort, and while he considered it invalid, he did feel that the study reflected Claimant's pulmonary capacity. However, this PFT is qualifying under the regulations. Thus, it is not clear from Dr. Broudy's statements how he could conclude Claimant was not totally disabled from a pulmonary standpoint. As Dr. Broudy failed to point to specific evidence which he relied on in drawing his conclusion, even though his opinion is well documented, I find it unreasoned. However, due to his advanced credentials, I accord his opinion some weight.

Dr. Dahhan opined after reviewing objective evidence that Claimant was totally disabled from a pulmonary standpoint and no longer possessed the respiratory capacity to continue his previous coal mining work or a job of similar physical demand. Dr. Dahhan considered the PFTs of record (both the valid and invalid ones), but also considered the medical reports of the physicians who examined Claimant. Given that Dr. Dahhan relied upon objective evidence in drawing his conclusions, even though he considered invalid PFTs, I still find his opinion to be well reasoned and well documented. Thus, given his superior credentials, I accord his opinion probative weight.

Here, I am most persuaded by Drs. Baker and Dahhan on the issue of total disability. They relied upon objective evidence, and in the case of Dr. Baker, relied upon his own physical exam in determining Claimant's total disability. In responding "no" when being asked if Claimant was totally disabled, Dr. Broudy did not articulate exactly what evidence he relied upon in drawing that conclusion – and the PFT he felt best reflected Claimant's pulmonary capacity was in fact qualifying. Therefore, accordingly, taken as a whole, the medical narrative

evidence supports a finding of total pulmonary disability. Thus, I find that Claimant has established total pulmonary disability under § 718.204(b)(iv).

Reviewing the evidence considered under § 718.204(b) as a whole, I find that Claimant has established that he is totally disabled due to a respiratory or pulmonary impairment under subsection (b)(2)(i) and (b)(2)(iv). Since the newly submitted evidentiary record establishes total disability, and this evidence differs "qualitatively" from the evidence previously submitted, Claimant's subsequent claim will not be denied on the basis of the prior denial. As a result, I will consider the entire record *de novo* to determine ultimate entitlement to benefits.

PRIOR MEDICAL EVIDENCE[24]

X-RAYS

Exhibit	Date of X-Ray	Date of Reading	Physician/Qualification	Interpretation
DX 1	11/20/2000	11/20/2000	Dr. Forehand / B-Reader	Negative
DX 1	11/20/2000	12/04/2000	Dr. Sargent / B-Reader, BCR	Quality 3, overexposed; negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results	Comments
DX 1 11/20/2000		59/72.0	2.81	5.05	103	56	No	

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO_2	pO_2	Qualifying	Comments
DX 1	11/20/2000	33 26*	69 87*	No No	

* Indicates Post-Exercise

Narrative Reports

Dr. Forehand examined Claimant on November 20, 2000. (DX 1). He considered the following: an age of 59 years; thirty-six years of coal mine employment, last working as a foreman; a family history of high blood pressure, heart disease, tuberculosis, cancer, allergies, and stroke; a personal history of attacks of wheezing (since 1970's), arthritis since the 1960's, and allergies since the 1960's; a smoking history of ten years (1983-1993 at a half pack a day); symptomatology of sputum, wheezing, dyspnea (for more than twenty years), cough, hemoptysis

[24] As the evidence contained within the original claim filed in 1993 is over ten years old, it is incorporated herein by reference only, except where specifically cited by Claimant or Employer. (DX 1). The evidence contained in the second claim is more recent and therefore more probative. Therefore, it shall be outlined in this opinion.

in 1993-94, chest pain, and orthopnea; physical examination revealing crackles at the left base with diminished breath sounds; and objective testing including an x-ray (0/0), PFT (obstructive ventilatory pattern), ABG (no hypoxemia at rest or with exercise; no metabolic disturbance), and an EKG (normal tracing). After examining all the above evidence, Dr. Forehand diagnosed mild chronic bronchitis which was the result of cigarette smoking and not coal dust exposure. He opined based on the objective testing that the impairment was "not significant" and Claimant still possessed the pulmonary capacity to return to his former coal mine employment.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§§ 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The record contains three newly submitted chest x-rays and one older chest x-ray.[25]

The first x-ray dated November 20, 2000 was interpreted by Drs. Sargent and Forehand to be negative. As there are no contrary interpretations, I find the November 20, 2000 film to be negative for pneumoconiosis.

The second x-ray dated May 24, 2004 was interpreted to be negative by Dr. Halbert. Dr. Alexander read the x-ray positive. As both physicians are equally qualified, I find this x-ray inconclusive for determining the existence of pneumoconiosis.

The third x-ray dated May 25, 2004 was read to be positive by Dr. Baker, who is a B-reader. However, Dr. Halbert, who is a dually qualified reader, interpreted the same x-ray to be negative. Due to Dr. Halbert's superior qualifications, I find his interpretation to be more persuasive. Therefore, I find the May 25, 2004 x-ray to be negative for pneumoconiosis.

The final x-ray dated September 9, 2004, was read to be negative by Dr. Fino. As there are no contrary interpretations, I find this x-ray to be negative for pneumoconiosis.

Considering the new x-ray evidence, I have found two of the x-rays to be negative for pneumoconiosis and one to be inconclusive. The older x-ray was also determined to be negative for pneumoconiosis. Thus, I find that the preponderance of the chest x-ray evidence does not establish the existence of pneumoconiosis. Therefore, I find that Claimant has not established the presence of pneumoconiosis under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

[25] The x-rays in the first claim are all over ten years old. As such, I find them to have little value in determining Claimant's present condition and accord them no weight.

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director*, OWCP, 7 B.L.R. 1-860 (1985).

DX 25 contains numerous medical reports from Drs. Alam and Bielecki, among others. While a few of the medical reports list pneumoconiosis as a current condition of Claimant, none of them are actually diagnostic. Not one report specifically outlines how either physician could conclude that Claimant has a pulmonary condition resulting from coal dust exposure. Many of the exams, as outlined above, detail Claimant suffering from wheezing and at other times, breathing normally. As there are no conclusions backed by reasoned analysis within these reports, I give them no weight for diagnosing pneumoconiosis.

The CT scan contained at DX 25 was taken to specifically diagnose coal workers' pneumoconiosis, and the causes of shortness of breath, and coughing. (DX 25). The CT scan specifically notes that there is no evidence of definite lung mass, only calcified granuloma and lymph nodes in the carinal area and AP window region.

Dr. Baker diagnosed clinical pneumoconiosis based upon a positive x-ray, employment history, and the physical examination. However, the x-ray he read as positive has been determined to be negative. This leaves Dr. Baker diagnosing clinical pneumoconiosis based upon decreased breath sounds and Claimant's employment history. However, Dr. Baker had the opportunity to examine Claimant and considered a correct smoking history. He based his findings upon a complete pulmonary evaluation in conjunction with a correct working history. As such, I find his diagnosis of clinical pneumoconiosis to be well reasoned and well documented. Thus, given his superior credentials, I accord Dr. Baker's diagnosis of clinical pneumoconiosis probative weight.

Dr. Baker also diagnosed legal pneumoconiosis based upon PFT testing, employment history, ABG, and his physical examination. He reasoned that Claimant's current pulmonary condition must be caused by coal dust exposure as Claimant's smoking history is "not significant," Claimant had not smoked since 1993, and there was "a lack of other significant

factors." Given that Dr. Baker diagnosed legal pneumoconiosis based upon objective evidence, a physical examination, and clearly articulated his opinion based upon that evidence, I find his opinion on the issue of legal pneumoconiosis to be well documented and well reasoned. Given his superior credentials, I therefore accord his opinion probative weight.

Dr. Alam provided a letter dated June 12, 2004 in which he stated that Claimant suffered from legal pneumoconiosis. He did not elaborate upon his findings, or articulate any objective evidence he considered in drawing his conclusion. Even though Dr. Alam saw Claimant many times over a span of a few years, because he failed to explain what objective evidence he relied upon, or how he came to this conclusion, I find Dr. Alam's opinion with regard to diagnosing legal pneumoconiosis undocumented and unreasoned. As such, I accord Dr. Alam's diagnosis of legal pneumoconiosis little weight.

Dr. Fino diagnosed legal pneumoconiosis (from moderately severe chronic obstructive bronchitis, a reversible bronchospasm and emphysema). He based this diagnosis upon a physical examination as well as objective testing (x-ray, PFT, and ABG). Dr. Fino reasoned that due to Claimant's lengthy employment history and due to the lack of smoking history, that coal dust exposure must be to blame for Claimant's current condition. Dr. Fino considered that Claimant smoked from half pack a day from 1983-1993 and a correct employment history. Given that Dr. Fino relied upon objective evidence, a physical examination, a correct smoking and employment history, and clearly articulated how that evidence led him to diagnose legal pneumoconiosis, I find his opinion well reasoned and well documented. As such, given his superior credentials, I accord Dr. Fino's opinion probative weight.

Dr. Broudy disagreed with Dr. Baker's analysis that Claimant suffers from legal pneumoconiosis. Specifically, Dr. Broudy stated that Claimant's pulmonary condition was the result of cigarette induced COPD with obstructive asthma. He noted the reversibility in the PFT studies, which according to Dr. Broudy is uncommon with patients' who suffer obstruction from a coal induced lung disease. He said a strong possibility was that the obstruction was caused by Claimant's smoking history. However, Dr. Broudy did not explain *how* a five pack year smoking history, and the fact Claimant had not smoked for over ten years, could be the sole etiology for Claimant's pulmonary condition. Furthermore, while Dr. Broudy notes reversibility – he does not address the fact that after bronchodialators are administered, Claimant's PFT results are still qualifying. As such, despite Dr. Broudy's advanced credentials, I find his opinion to be unreasoned. Therefore, I accord his opinion little weight.

Concerning clinical pneumoconiosis, Dr. Broudy simply responded to a question asking if, in his opinion, Claimant suffered from clinical pneumoconiosis. Dr. Broudy responded that based on his review of the record, Claimant did not. In this, Dr. Broudy did not specifically state what objective evidence he relied on, or how the objective evidence led him to conclude differently than other physicians (such as Dr. Baker). I find this to be unreasoned for the purposes of diagnosing clinical pneumoconiosis. As such, I accord his opinion on this issue little weight.

Dr. Dahhan opined that Claimant does not suffer from clinical or legal pneumoconiosis. Concerning clinical pneumoconiosis, Dr. Dahhan noted that most of the radiographic evidence

did not indicate the presence of the disease. Furthermore, the CT scan which was taken was also negative for the disease. Concerning the physical symptoms, Dr. Dahhan notes that the history of PFTs, even the invalid ones, all show reversibility. This in conjunction with the frequent wheeze and shortness of breath (which at times exists, and at times does not), leads him to conclude that Claimant suffers from bronchial asthma. As bronchial asthma showing reversibility, in his opinion, is a condition of the general population, and is not caused by the inhalation of coal dust, Dr. Dahhan concluded by stating his condition was not the result of coal dust exposure. Dr. Dahhan did fail to mention the fact that even after the reversibility, Claimant's PFTs were still qualifying. However, because Dr. Dahhan pointed to specific objective evidence with which to draw his conclusion and clearly articulated his opinion – I find his opinion regarding both clinical and legal pneumoconiosis to be well reasoned and well documented. As such, given his superior credentials, I accord his conclusions probative weight.

Dr. Forehand, whose examination was apart of the previous claim, concluded that Claimant did not suffer from clinical or legal pneumoconiosis. He relied upon his own objective evidence, including a negative x-ray, PFT testing, ABG testing, and his own physical examination. Dr. Forehand concluded that Claimant suffered a mild chronic bronchitis which would result from cigarette smoking and not coal dust exposure. As Dr. Forehand considered objective evidence and clearly articulated his opinion based upon that objective evidence, I find his opinion to be both well reasoned and well documented. However, due to its remoteness, I only accord it some weight.

Concerning clinical pneumoconiosis, I have found two opinions well reasoned and well documented. I am most persuaded by Dr. Dahhan. Dr. Dahhan – who had a complete picture of Claimant's history – clearly articulated why Claimant did not possess clinical pneumoconiosis. He noted such a diagnosis was not supported by radiographic evidence or the CT scan. Furthermore, he noted the consistent reversibility in the PFTs suggested bronchial asthma, which was consistent with Claimant's history of wheezing. I find this explanation by Dr. Dahhhan to be the most convincing. As such, Claimant has failed to establish the existence of clinical pneumoconiosis.

Regarding legal pneumoconiosis, I have accorded two opinions diagnosing the condition probative weight by Drs. Baker and Fino, while giving some weight to Dr. Forehand's opinion, and probative weight to Dr. Dahhan's opinion – both of which stated Claimant did not suffer from legal pneumoconiosis. Here, I am most persuaded by Drs. Baker and Fino. First, they both had the opportunity to recently examine Claimant, where Dr. Dahhan did not. Second, they both clearly articulated their opinion that a lack of a lengthy smoking history could not be responsible for Claimant's current pulmonary condition. Furthermore, Dr. Baker specifically articulated why he disagreed with a diagnosis of asthma, as there was nothing in the record to support such a diagnosis. As such, I find Claimant has established the presence of pneumoconiosis under subsection (a)(4).

Claimant established the presence of pneumoconiosis under subsection (a)(4). Therefore, I find that Claimant has established pneumoconiosis under § 718.202(a).

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. § 718.203 (2003).

If a miner suffers from pneumoconiosis and was employed ten years or more in the Nation's coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b); *Stark v. Director,* OWCP, 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.*, 9 B.L.R. 1-137 (1986). As I have found that Claimant has established thirty-two years of coal mine employment, he is entitled to this rebuttable presumption. Every physician who opined that Claimant suffered from legal pneumoconiosis opined that it was the result of coal dust exposure Claimant inhaled during his thirty-two years of coal mine employment. Drs. Broudy and Dahhan opined that Claimant did not suffer from legal pneumoconiosis – and I found both these opinions unreasoned. Therefore their opinion regarding the etiology of pneumoconiosis cannot be well reasoned. As such, I find Employer has not rebutted the rebuttable presumption located at § 718.203(b).

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether Claimant's total disability was caused by his pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in §§ 718.305 and 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2). The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal Co. v. Smith*, 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under § 718.204) was due - at least in part – to his pneumoconiosis. *Cf.* 20 C.F.R. 718.203(a); *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's impairment is due to his combined dust exposure, coal workers pneumoconiosis as well as his cigarette smoking history is sufficient). More recently, in interpreting the amended provision at § 718.204(c), the Sixth Circuit determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal

dust." *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001). A miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id*.

As stated above, I accord more weight to the newly submitted evidence of record based on its recency and the progressive nature of pneumoconiosis. *Gillespie*, 7 B.L.R. 1-839. The reasoned medical opinions of those physicians who diagnosed the existence of pneumoconiosis and found that Claimant was totally disabled are more reliable for assessing the etiology of Claimant's total disability. *See, e.g. Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). Here, Dr. Baker opines that Claimant's totally disabling pulmonary condition is the result of both coal dust exposure and cigarette smoking. Since this conclusion is based on history of exposure, an accurate employment history, as well as the results of the objective testing, I accord it probative weight. As for Dr. Dahhan, he finds that Claimant is totally disabled by a pulmonary impairment, but not from the result of coal mine employment or pneumoconiosis. As this is contrary to my finding of pneumoconiosis, I accord his opinion little weight. Dr. Broudy concludes that Claimant does not suffer from pneumoconiosis, nor is he totally disabled. As this is contrary to my finding of pneumoconiosis and total disability, I accord his opinion little weight. Dr. Alam opines that Claimant is totally disabled by pneumoconiosis, but fails to articulate any objective evidence or provide a rationale for his conclusions. As his opinion is equivocal and vague on the etiological issue of total disability, I accord it no weight.

Here, I am most persuaded by the opinion of Dr. Baker, who relied upon objective testing and clearly articulated his opinion as to why Claimant was totally disabled by pneumoconiosis. This opinion consisted of an accurate employment and smoking history. As such, I find Claimant has established he is totally disabled by pneumoconiosis.

Entitlement

Claimant has established a material change in conditions sufficient to meet the statutory requirements of § 725.309(d). Considering both the previously submitted and newly submitted medical evidence, Claimant proved that he has pneumoconiosis arising from coal mine employment, and that his total disability is due to pneumoconiosis. Therefore, Claimant is entitled to benefits under the Act.

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein, as no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application, with a service sheet showing that service has been made upon all parties, including Claimant. The parties have 10 days following receipt of any such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval. *See,* §§ 725.365 and 725.366.

ORDER

IT IS ORDERED that the claim of B.S. for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013- 7601. *See* 20 C.F.R. §§ 725.478 and 725.479. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).